

"They're made in factories and not by witches on the allotment"

Lindenmeyer, Antje; Jamie, Kimberly; Griffiths, Frances; Légaré, France

DOI:

[10.1080/07399332.2011.603864](https://doi.org/10.1080/07399332.2011.603864)

License:

Other (please specify with Rights Statement)

Document Version

Peer reviewed version

Citation for published version (Harvard):

Lindenmeyer, A, Jamie, K, Griffiths, F & Légaré, F 2011, "They're made in factories and not by witches on the allotment": a qualitative study of midlife women in the United Kingdom, exploring their approaches to complementary and alternative medicines', *Health Care for Women International*, vol. 32, no. 12, pp. 1046-67. <https://doi.org/10.1080/07399332.2011.603864>

[Link to publication on Research at Birmingham portal](#)

Publisher Rights Statement:

This is an Accepted Manuscript of an article published by Taylor & Francis in *Health Care for women International* on 1st December 2011, available online: <http://www.tandfonline.com/doi/abs/10.1080/07399332.2011.603864>.

Eligibility for repository checked October 2014

General rights

Unless a licence is specified above, all rights (including copyright and moral rights) in this document are retained by the authors and/or the copyright holders. The express permission of the copyright holder must be obtained for any use of this material other than for purposes permitted by law.

- Users may freely distribute the URL that is used to identify this publication.
- Users may download and/or print one copy of the publication from the University of Birmingham research portal for the purpose of private study or non-commercial research.
- User may use extracts from the document in line with the concept of 'fair dealing' under the Copyright, Designs and Patents Act 1988 (?)
- Users may not further distribute the material nor use it for the purposes of commercial gain.

Where a licence is displayed above, please note the terms and conditions of the licence govern your use of this document.

When citing, please reference the published version.

Take down policy

While the University of Birmingham exercises care and attention in making items available there are rare occasions when an item has been uploaded in error or has been deemed to be commercially or otherwise sensitive.

If you believe that this is the case for this document, please contact UBIRA@lists.bham.ac.uk providing details and we will remove access to the work immediately and investigate.

“They’re made in factories and not by witches on the allotment”: a qualitative study of midlife women in the United Kingdom, exploring their approaches to complementary and alternative medicines

Antje Lindenmeyer¹, Kimberly Jamie², Frances Griffiths¹, France Légaré³

1) Health Sciences Research Institute, University of Warwick, UK

2) Department of Sociology, University of York, UK

3) Department of Family Medicine, Laval University, Quebec, Canada

Abstract

This article explores midlife women’s experiences and approaches related to complementary and alternative therapies (CAMs). 96 midlife women were asked about their use of CAMs as part of their overall approach to midlife health. Qualitative thematic analysis was combined with a case based approach. Women set their experience of CAMs in the context of conventional medicine taking and discussed their safety and different uses. For treatments requiring direct contact with a practitioner, accessibility and quality of the relationship were crucial. Four overall approaches could be discerned (political-critical, pragmatic, careful and wellbeing-oriented) which dynamically interacted with women’s experiences.

Declaration

The authors state that this manuscript has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere.

Keywords

Aging, Menopause, Complementary Medicines, Alternative Medicines, Qualitative Methods

In this article, we explore midlife women's approaches to complementary and alternative medicines (CAMs) as part of a qualitative study of women's experiences of health at midlife in the United Kingdom. The experiences of women in our study, most of whom had used or considered some form of CAMs, can be seen in the context of a worldwide increase in the use of complementary and alternative therapies (Astin, 1998; Goldstein, 2000). Here, we explore why women choose to use CAMs to improve midlife health in the context of medication taking overall, and we look at the perspectives of women who did not use CAMs or stopped using them. We will also aim to find out whether a more overall approach to CAMs or medication taking may have influenced their choices, in addition to more immediate experiences such as menopausal symptoms.

In recent years, growing numbers of women have been seeking complementary and alternative medicines for menopausal symptoms (Parkman, 2003; Will & Fowles, 2003). Authors conducting surveys of midlife women from the United Kingdom (Vashisht, Domoney, Cronje, & Studd, 2001), the United States (Bair, et al., 2005) and Australia (Gollschewski, Anderson, Skerman, & Lyons-Wall, 2004) found that over half of their respondents used some form of complementary and alternative medicines or therapies. CAMs use by menopausal women could be linked to demographic factors, for example older age (Newton, Buist, Keenan, Anderson, & LaCroix, 2002), higher educational achievement and higher socio-economic status (Vashisht, et al., 2001) and the existence of concurrent chronic illness (Wathen, 2006). However, the higher cost of CAMs

administered by a practitioner was a barrier (Gollschewski, Kitto, Anderson, & Lyons-Wall, 2008; Wathen, 2006). Dissatisfaction with conventional medicine, especially in relation to the perceived safety of CAMs also influenced some women's decision to use CAMs (Wathen, 2006; Will & Fowles, 2003). Personal reasons for choosing for example herbal remedies were the persistence of menopausal symptoms and perceived absence of risk and side effects, relative cheapness and availability (Gingrich & Fogel, 2003; Vashisht, et al., 2001).

Authors of qualitative studies in this area (Gollschewski, et al., 2008; Richter, Corwin, Rheume, & McKeown, 2001; Seidl & Stewart, 1998; Suter, et al., 2007; Wathen, 2006; Will & Fowles, 2003) additionally focused on women's information needs and sources of information about CAMs, primarily friends and family members (Suter, et al., 2007; Will & Fowles, 2003). This 'peer information', could be enriched with women's experience of their own bodies (Banister, 1999). In our analysis of midlife women's accounts of CAMs use, we will take a step back from women's choices, looking at more overall approaches to CAMs (such as openness to everything that 'works') and how they interact with women's experiences and other information to shape perceptions of CAMs and influence CAMs use.

Women's choices around CAMs use are often discussed as an 'alternative' to hormone replacement therapy (HRT). HRT is the term used in the UK for hormones (estrogen and progestagen or estrogen alone) used by women who are going through or have been through a natural or surgery induced menopause. Although hormone replacement therapy

is known to be the most effective treatment for the management of menopausal symptoms, the results of the Women's Health Initiative postmenopausal hormone therapy trials have influenced many women into discontinuing or refusing this therapy (Hersh, Stefanick, & Stafford, 2004). However, some women use both HRT and CAMs concurrently (Newton, et al., 2002): indeed, one study found that CAMs users were using more conventional health-care resources than women who did not use CAMs (Bair, et al., 2005). The necessity, or otherwise, of HRT is a crucial element in the debate on the status of menopause either as a deficiency disease with 'symptoms' or a natural life stage to be embraced (Murtagh & Hepworth, 2003). Some feminist critics have addressed the medicalization of menopause and the presentation of HRT as a tool to maintain women's attractiveness and availability to men (Greer, 1991). This dichotomy between the medicalised menopause (centred around maintaining femininity) and the 'natural' menopause (centred around acceptance of a new life phase) has however been criticized by other feminist writers as a simplification of the experiential complexity of bodies and hormones for midlife women (Leng, 1996; Roberts, 2002), compounded by cultural assumptions around age and gender (Gullette, 2004). According to these authors, women's midlife is shaped by a complex interaction of physical, emotional and social experiences. As it would be counterproductive to separate the experience of menopausal 'symptoms' from understandings of life and health overall, we include any use of CAMs for midlife-related health (rather than tightly defined symptoms such as hot flushes) in our analysis.

Methods

We report results from an interview study of women's use of midlife-related health interventions including HRT, breast screening programmes, breast awareness, bone densitometry for osteoporosis and self-care such as diet, exercise and the use of CAMs conducted in two different regions of the United Kingdom (Griffiths, et al., 2003). Other aspects of the study have been reported elsewhere (Griffiths, et al., 2006). 98 women were recruited for diversity across a number of different healthcare sites (HRT clinic; bone densitometry clinic; breast assessment clinic; general practice, well woman clinic). Women from relevant community organisations were recruited for diversity of ethnicity, sexual orientation and disability. Demographics were obtained by asking participants to fill in a brief questionnaire at the end of their interview (see table 1). Interviews were conducted between 2001 and 2003; therefore, the growing media interest in the results of the Women's Health Initiative study in the US and the Million Women study in the UK (Million Women Study Collaborators, 2003) forms part of the backdrop of this study, even though none of the participants explicitly mentioned these studies.

In our study, we aimed to obtain women's understandings of midlife health, taking into account the diversity of women's experiences and the complex web of individual and social meanings given to health interventions such as HRT. To explore these, we used a qualitative methodology. During semi-structured interviews with a woman researcher, women were asked about their health concerns in general, their views regarding HRT, mammography and bone densitometry, and their experiences of interacting with health professionals. An open-ended, iterative process shaped the interviewing and recruitment

process to explore emerging themes and perspectives; for example, 5 women who had opted not to use any of the health interventions discussed were recruited to understand the views of this particular group. 63 individual participants and 3 jointly interviewed lesbian couples were asked whether they had used any form of CAMs on its own or alongside HRT. If yes, they were invited to discuss their experiences. This item was introduced when the interview schedule was updated following early stage analysis, and therefore the question was not asked in interviews with the initial 26 women; in three other interviews, the question was also omitted. The aim was to find out about the women's use of and approaches to CAMs (not specific to menopausal symptoms) within the context of their experiences and views of the menopause and midlife health in general. Responses varied from short answers to longer explorations of the different meanings and uses of CAMs.

Interviews were entered into N-vivo for ease of retrieval, and the section on CAMs extracted. Using N-vivo's search function, other mentions of CAMs (e.g. 'alternative'; 'natural') were also identified. As we aimed to focus both on women's perceptions of specific CAMs and their overall approaches, thematic coding followed two different approaches: KJ developed codes for themes related to women's views of CAMs while AL treated each interview as a 'case', summarizing each women's approach to CAMs as a whole. This approach draws on case-based sociological approaches to complex interactions (Griffiths, 2009; Miles & Huberman, 1994) and has successfully been used by members of the research team to understand and contextualize complex individual dynamics such as living with chronic illness over time (Griffiths, Manazar, Chow, Anto

et al., 2007). Our approach assumes that women's experiences and choices can best be explained not by isolating individual factors (e.g. severity of menopausal symptoms) or psychological traits (e.g. desire for control) but by understanding their interaction with an overall approach to health in general and CAMs in particular.

Definitions of CAMs

A central difficulty of defining CAMs is the fact that a treatment considered complementary within one context may be seen as mainstream in another; some treatments such as cognitive behavioural therapy (CBT) once considered alternative are now mainstream (National Centre for Complementary and Alternative Medicine, 2007). To understand and categorise different types of CAMs, we used the wide-ranging definition of the Cochrane Complementary Medicine Field: complementary medicines include practices and ideas which are outside the domain of conventional medicine in several countries and defined by its users as preventing or treating illness, or promoting health and well being. Their definition also distinguishes between treatments a person largely administers to him or herself, treatments providers administer, and treatments a person administers to him or herself under the supervision of a provider (Manheimer & Berman, 2008).

For our analysis, we simplified this distinction into personal use CAMs that were available 'over the counter' (e.g. supplements or herbal remedies purchased from shops and other outlets where there is no practitioner guidance) and physical contact CAMs that required a trained practitioner (e.g. reflexology, acupuncture). None of the participants

mentioned treatments they self-administered under the supervision of a provider such as meditation or Qi Gong; however, one participant mentioned taster sessions in homeopathy, and another received guidance on herbal remedies from staff at her local health food store. Women were not directly asked whether they were using CAMs for menopausal symptoms as we did not want to presume what women might consider menopausal symptoms.

Women's use of CAMs

Women talked about using a variety of treatments for of their own health and generally and specifically for midlife health issues. As we were interested in overall approach to CAMS, we included any use of CAMs in our analysis. Only 6 had never used CAMs and did not talk about possibly using them at a later point (see figure 1). Definitions of CAMs were initially researcher-led as the interviewer introduced examples (aromatherapy, supplements) if the interviewee was unsure what was meant by CAMs. Some of these could be considered as not 'alternative' by participants such as cod-liver oil for joint pain. We started out with a general research question of how women defined and used CAMs. While analysing the data, we found that the experience of using 'over the counter' CAMs was different from using 'physical contact' CAMs, although some women had used both. While both were seen in the context of other medication women were taking (especially HRT), for the latter, the 'hands on' relationship with the practitioner was an important element, as was the cost of practitioner time. We therefore refined the research questions addressed in this article to include:

- 1) How do midlife women define and use over the counter CAMs and physical contact CAMs in the context of medication taking overall (including HRT)?
- 2) How does direct contact with a practitioner impact on the experience of physical contact CAMs?
- 3) Do midlife women express an overall approach to CAMs which might influence their decisions to use or consider using them?
- 4) Is this approach linked to the type of CAMs women are using?

Results

‘Over the counter’ CAMs

The 39 women who used ‘over the counter’ CAMs described a wide spectrum of remedies and supplements including evening primrose, black cohosh or combined preparations for ‘the menopause’ e.g. hot flushes. Others used herbal remedies that may have been for menopause related health issues, such as ginseng to improve libido, tea tree oil for vaginal problems, valerian to improve sleep and eyebright for eye irritation. Supplements and vitamins were also taken to address other midlife health issues such as joint problems (glucosamine, cod-liver oil) heart health (garlic capsules) and to boost health and wellbeing in general.

Context of overall medication taking

The experience of using over the counter CAMs was often described in relation to the experience of medicine taking in general and HRT in particular. Several women stressed the difference between CAMs and HRT and other conventional drugs that could be potentially harmful:

... [CAMs] are classed as beneficial without being harmful (woman05)

...even if they're not doing you any good let's say they're not doing you any harm (woman76)

... if they're natural they um, they shouldn't be any harm from them (woman89)

This was often linked to CAMs being closer to nature and therefore the body's own processes, in contrast to industrially produced conventional medicines.

However, the majority of women used both conventional and complementary medicines. Most considered using CAMs for minor ailments while reserving more powerful prescription medications for more serious health problems:

[Tea tree oil] is a most wonderful cure for any of those sort of little umm, minor irritations that occur umm, before resorting to doctors if it doesn't clear up and you've got to go for one of the big, err, 'big bombs' as we call them for treatment. (woman07)

In contrast, one woman said that those taking CAMs should not use conventional medications as they made especially homeopathic remedies ineffective. Others were reluctant to take both together or because they could interact, resulting in side effects:

You can't take those if you're taking HRT. So. 'Cause it's dangerous. (woman22)
...if [CAMs] are natural, there shouldn't be any harm from them, but combined with the drug there might be something that interacts with whatever you're taking. (woman89)

Reluctance to take any medicines

While most women were ambivalent towards taking conventional medicines, some were very reluctant to take too much medication or any at all. This could include herbal as well as conventional medicines:

I rattle as it is and isn't just like, is it worth it (woman80)
I would rather do relaxation exercises, deep breathing or whatever ... you either have one or the other because if you do both you could be overloading your body. (woman02)
... they give you all these pills. Instead of what's your diet, what's your lifestyle like? And that's what we should be looking at more, not tablets. (woman46)

In addition to the concern of ‘overloading’ the body, the aversion to ‘tablets’ or ‘pills’ was sometimes expressed as a favourable personality trait: they were not the kind of person that goes for quick fixes: “never been a pill taker” (woman79) “I do get fed up of taking tablets” (woman80). “I don’t take medicines at all. If I have a headache I go for a walk.” (woman90) For women taking this approach, health was something to be worked at regularly “... as a way of just being more healthy in my life rather than being symptom-led” (woman29)

CAMs as empowering choice

Several women perceived an important difference between prescription medication and CAMs in that they themselves researched and chose the remedies they were taking. With time spent looking at alternatives, they could become experts in their own health:

I certainly read, and I’ve read quite a bit about herbs ... My children come to me and ask me, what can I take for this? (laughs) Have a look in your book, see what I can take for this. (woman47)

There’s a bit of the brain that keeps thinking “well I really ought to be in charge and doing something about this” ... we realise our GP’s hands are tied and they don’t know as much about nutrition as we would like them to and we then start reading for ourselves. (woman07)

For some of the women, this was linked with midlife being a release from caring responsibilities and therefore a good time to take control of their own health:

I certainly do take more supplements now ... it’s up to me and I really ought to be start taking control of what I’m doing. (woman73)

Exercise and, you know, walking, the fresh air, different way of life, different way of looking at things. It's like I've given myself permission now, and it's all right to do that. ... Instead of—I've always been a bit of a care-taker and a people-pleaser. (woman41)

'Over the counter' CAMs: Summary

In our study, women reported many different uses of 'over the counter' CAMs in relation to the menopause or midlife health in general. When asked about their CAMs use, women linked CAMs with overall medicine use. While some regarded CAMs as less harmful and therefore essentially different from other medicines, others considered using both together or were averse to any oral medication use. A few women saw CAMs as an area over which they themselves had control, especially as they saw midlife as a time where they could take control over their health and lives.

Physical contact CAMs

16 participants currently used physical contact CAMS where the presence of a therapist was required. As research of CAMs at menopause mainly focuses on herbal remedies such as black cohosh and evening primrose, the use of physical contact CAMS in this context has not been widely researched; however, some authors have reported positive effects of acupuncture for the treatment of hot flushes (Borud, et al., 2009; Walker, de Valois, Davies, Young, & Maher, 2007). The majority of women in our study used physical contact CAMs for back or neck pain, or to achieve more general wellbeing. Five women with multiple sclerosis were recruited through an MS centre where Shiatsu and reflexology were on offer to relieve their symptoms. One woman had tried several

treatments, among them acupuncture and aromatherapy, to reduce menopausal hot flushes as she could not use HRT.

Physical contact CAMs in the context of medication taking

Similar to those using ‘over the counter’ CAMs, women who valued physical contact CAMs contrasted them with medications like HRT, describing them as ‘hands-on’: “natural hands-on techniques” (woman71) or “hands-on kind of things that have always been there” (woman41). Unlike impersonal medical technology “it's touch and feel which is more in keeping with what I feel about having tests... you can't [touch and feel] with a machine” (woman69). Two women who were treated with Shiatsu at their MS centre saw this technique as ‘ancient wisdom’ (woman46) compared to new and relatively untested conventional drugs:

Shiatsu for example that the Chinese have been using for many, many hundreds of years ... A lot of things are sort of things that have been handed down — even science I think is finding that some of the things work. (woman76)

Access to physical contact CAMs

Another important aspect of practitioner-guided CAMs was the relative ease of access. One woman had extensive consultations with staff at the health food shop “at the top of the road” (woman03) whom she preferred to her GP for health advice; and others mentioned local practitioners:

Soaps and things isn't it. The lady up the road does it. (woman18)

A lady lived along the road who was doing her homeopathy course and she came and talked to us about what was available and showed us. (woman07)

Accessibility of a practitioner became more of an issue with possibly expensive physical contact treatments. One woman said her GP referred her in spite of his misgivings: “when I said could he write a note for the [MS] centre ... he said you know there’s no proof that it works. So he has sort of pooh-poohed it, but I still go” (woman76). Some women gained access to trainee practitioners: one woman’s sister (woman39) and one woman’s daughter (woman40) had done courses in aromatherapy and reflexology and practiced on them. Another (woman02) used a trainee acupuncturist.

Problematic experiences with physical contact CAMs

However, closeness to the practitioner could also be problematic when difficult areas were probed too deeply and it was felt that practitioners were not dealing with the pain they had uncovered:

I had nearly two years of acupuncture ... my very keen pupil-practitioner felt that I’d got bigger and deeper problems (laughs). ... After eight years of (laughs) psychotherapy (laughs) I’d come to the realisation at the end of eight years that some things couldn’t be changed, they’d just got to be lived with. (woman02)

I have tried the reflexology, and or ... no, I wouldn’t do ... advise anybody to do it. Because she knew I had a back problem um, she focused on the part of the feet that affect the back. And I was in agony when she’d finished (woman24)

A few women were fascinated with what they saw as the practitioners’ intuitive powers of touch and feel. This could be problematic as there is a possibility that unscrupulous

practitioners could offer treatments for non-existing illness. Being diagnosed with ailments they did not even know they had was ‘almost like palm reading ... like magic’ (woman07):

My daughter does reflexology ... she was doing my feet as part of her final study thing ... And she said to me, have you got any trouble with your water works? And I says, no, I’ve never had any trouble. And then, ten days later, I had the—I’d never had a water infection, and she’d almost—she diagnosed it. (woman40)

However, therapist-administered treatments at the more unconventional end of the spectrum, like ‘shamanistic massage’ or ‘chanting’ (woman26) attracted criticism even from long-time CAMs users.

Physical Contact CAMs: Summary

While ‘over the counter’ CAMs could be self-administered, physical contact CAMs introduced a closer relationship with the therapist. This ‘hands-on’ nature of therapy was seen as an advantage by participants, but also resulted in increased cost and reduced accessibility. Participants described both positive and negative aspects of close physical contact between patient and therapists, to the point of diagnosing ailments by feel and touch.

Overall approach to CAMs:

Although we could identify specific factors influencing midlife women’s use of CAMs as described above, their overall ‘approach’ to CAMs could also be discerned. Some women described more in detail how their approach to CAMs was influenced by personal

experiences but also in turn influenced how these experiences were understood. For example, one participant considered HRT after undergoing hysterectomy:

“And they explained about HRT, and I was always saying that I was not terribly keen on that, and they said, well, you won’t have much choice. And I said, well I think I will because I’ll look into it for myself, and look at, you know, more complementary routes. I have kept my ovaries, and I believe I’m still doing well.” (woman31)

In order to capture these understandings of CAMs, AL summarized the ‘overall approach’ from each interview. The following are examples of these summaries:

Need to find alternatives as can't take HRT, trying out from 'list of things', closer to nature and ‘what God provides’ (woman46)

Should be careful with anything taken orally, even CAMs, not to 'overload' the body (woman02)

From these summaries, we developed four categories (Political-Critical, Pragmatic, Careful and Wellbeing-Oriented) and women were allocated one of these categories. If women seemed to have an approach to CAMs that fitted with more than one category, they were placed in the category that was most dominant in the interview. For example, woman07 moved between a pragmatic approach (positive towards trying out CAMs if they work) and a careful approach (concerned about side effects of CAMs); however, the second approach was expressed more frequently in the interview. Two interviews did not contain enough information to categorise.

Political-critical approach

A political-critical stance towards conventional medicine was expressed in interviews with 11 women (including 7 of the 10 women identifying as lesbians). These were the most vocal advocates of CAMs. Many voiced a feminist standpoint, defending their right to make choices about their own body; some were opposing much of conventional medicine on principle as they saw it dominated by the interests of drugs companies or an impersonal 'by numbers' approach. CAMs were seen as natural and more closely related to women's bodies than conventional drugs based on chemicals. Some expressed this point very strongly, for example by describing drugs as 'pollutants':

I don't see why I should be polluting my body in one way while I'm trying to save it from something else. I would rather take something that was natural that was working with my body and was not having any side effects whatsoever. (woman79)

I see things like acupuncture and homeopathy um, working with the body's natural defences if you like and working to build the body and keep the body well. Whereas I see [medical] technologies as just intervening when there's something bad. (woman29)

The women in this category usually posited a strong dichotomy between CAMs, nature, and working with the body on the one hand and conventional medicine, chemical industry, and overwhelming the body on the other. However, some also made more complex points, for example that CAMs had become increasingly industrialized and therefore more similar to conventional drugs:

they're increasingly made in factories and not by witches on the allotment ... Nelson's, they are getting quite big and probably you know probably they use, not the same processes but the sort of same, the same way of grinding things down. (woman03)

Others found that despite their critical stance they also depended on interventions from conventional medicine, for example medications for diabetes or HRT:

Every so often I think “Why should I be shoving all these drugs in me?” ... I think I do get, sometimes, a bit wary about putting drugs into you. But I think the relief that [HRT] gives you ... outweighs anything else at the moment. (woman08)

Pragmatic approach

The largest group of women (40) had a pragmatic approach, concentrating on ‘what works’. They focused on CAMs as a cure or a way of improving symptoms of illness, from minor ailments to disabling conditions such as MS. Some were positive towards CAMs, citing examples where they had helped them or people they knew; others however were sceptical as they had tried CAMs with no discernible effect or found conventional medicine more trustworthy. Those who were positive often favoured a combined approach of conventional medications and CAMs, as they did not want to miss out on possibly helpful treatments: “the more the merrier” (woman39); “whatever gets you through the night, I think. I wouldn't be for one or the other” (woman40). Using CAMs could also imply a personal choice to focus on helping oneself:

I certainly do take more supplements now ... it's up to me and I really ought to be start taking control of what I'm doing (woman73)

...go and get them but you don't get them on prescription [for MS] that you have to take.

It's just help if you want it, it's your decision if you want to go and get things like evening primrose. (Woman75)

Some women focused on feeling pain or distressing hot flushes where even small or short-lived improvements could make a difference.

what's going to help you on the day really, even if it only gives you a couple days' relief
(woman37)

I think a lot of women—you need all the help you can get sometimes (woman41)

Many women focused on personal experience and were positive towards CAMs if they felt a benefit, especially where conventional medicine did not seem to have any effect:

... my skin was bad, really. It were down to the bone. ... All my hands and face and...oh it was awful. So, I mean, when you're like that and the hospital isn't doing any good, in fact it's making it worse, um, you try everything. (woman90)

Smaller improvements through physical touch therapies such as osteopathy or chiropractic manipulation were also noted where conventional therapies failed:

...we've used acupuncture for my son, because he had RSI when he was at university, all the note-taking—in his wrist, and we tried everything else, we tried tab—you know, drug therapies and what have you, so we did try acupuncture. So yeah, I mean, I—again, I think that they have a place in—in modern society. (woman33)

However, a few women with pragmatic approach were more ambivalent or sceptical towards using CAMs. Some were critical they had experienced no real effect: “it's more a placebo thing, you just feel better for having it, or using these things, rather than it does you any good” (woman16). Some described a trial and error process as they found that some CAMs worked for them while others did not:

Definitely sitting on the fence. Some I like and others I think are too blah, blah ... you read about them in the papers and magazines, and you hear about them on the radio, and

the TV. And sometimes you try them out. You know. This one seems to work, and that one doesn't. I've tried acupuncture. No help at all. I've tried aromatherapy. Very pleasant, but it hasn't actually helped anything (laughs). (woman25)

One participant said that she could not be sure whether she would not be worse without using CAMs and used them 'as a sort of safeguard' (woman04). Others were unsure whether CAMs had any effect on them at all as any improvement might have occurred anyway. A few women believed CAMs had had no effect on them and might even have negative effects. The motives of those selling expensive CAMs who might be "somebody trying to make money quick" (woman21) were also questioned. Others simply saw CAMs as not 'for them':

I have friends who say, acupuncture, and all this meditation, and I think, oh no, not for me. (woman09)

Never used them. I've always been to my GP. (woman28)

Careful approach

In contrast to the trial and error process advocated by the pragmatic approach, 10 women were focused on safety of treatment and side effects. These were mainly related to 'personal use' CAMs. Some, as described above, were concerned about side effects of conventional medication and favoured CAMS. Others were worried about effects of combining both:

I wouldn't think, you know, I wouldn't put a pill into my mouth that I would think would... because I take other medication ... I would never take any sort of other pills without consulting my doctor (woman30).

Others saw both CAMs and conventional medicines as powerful and therefore able to cause side effects:

... one of the difficulties is that they are portrayed as being - even homeopathy, oh these oils are quite safe to take, - they're not, they're very harmful and dangerous, and you really do need some good books to read ... before you start using them. (woman07)

Two women with diabetes were wary of any treatment that might affect their condition:

I'm scared to take anything like that in case it affects my diabetes... And I know you can't use the foot spas when you're diabetic. You can't use them. So, some reason, I don't know why. (woman92)

Wellbeing-Oriented

Six women focused on the potential of CAMs to enhance overall wellbeing in general.

This approach was often taken by women who favoured physical touch CAMs. However, these treatments are described more as a luxury than a necessity, with cost an important barrier:

It all costs money that doesn't it. My partner now and again does aromatherapy on my legs and that and my feet, which is very nice, and err 'oh to be pampered' (Woman80)

The most enthusiastic descriptions were made by two women who did not use any CAMs at all but would favour aromatherapy or massage if they could afford it:

Just to lay there and let somebody do it, I'd just go into a world of my own (woman91)

It's just nice to be able to have something done to you. For a change, you know. Rather than you do something to somebody else, or for somebody else ... like me with arthritis—

painful, you know. If you could ease it for a day, or perhaps two days, that would be wonderful. (woman42)

While these CAMs are described as a kind of luxury, like a spa treatment, it also seems that these two women are also looking for more than symptom relief. Aromatherapy is described here almost like a kind of antidote a busy and hardworking life, enabling women to relax instead of rushing around, to have someone tend to their needs instead of tending to others’.

Links between an overall approach and CAMs used

Women’s overall approach to CAMs were linked to their CAMs use overall (see Figure 2): a large percentage (73%) of women whose political-critical viewpoint implied a positive stance towards CAMs currently used them, and the remaining 27% considered its use in future. Of those with a pragmatic stance, almost as many (69%) currently used CAMs; however, 8% (3 women) had no intention to use them in the future. They also used a wider range of treatments, but this could be a result of the large size of this group comprising over half of participants. A smaller percentage of those with a careful approach used CAMs (50%), and only 2 women with a ‘wellbeing’ approach used a mix of over the counter and physical contact CAMs; the others described the ‘idea’ of enhanced wellbeing through CAMs rather than a personal experience. Experience, overall approach and choice of treatment seemed to be connected for some of the women.

However, these links need to be interpreted with caution, as 3 of the 4 groups were very small and the data not specifically collected for this purpose.

Discussion

In our study, we captured women's overall approach to health at midlife, including views from women who used CAMs, had tried but rejected CAMs, or had never considered using them. Participants reflected on the use of many different forms of CAMs for menopausal problems and midlife health overall. This was both a strength and limitation of this study. Women's responses were to a set of very open questions, neither focusing on specifically menopausal symptoms nor decisions to use particular treatments. While the desire to reduce side effects and find treatments that worked was overarching, different sets of issues related to different kinds of treatments (personal use, physical contact). Accessibility and relationships with practitioners was also important.

Perspectives on personal use CAMs were strongly related to discourses on medications in general. Concurrent with other qualitative studies of medicine taking, most participants were ambivalent about use of prescription medications (Pound, et al., 2005). Their responses could be linked to a set of 'interpretive repertoires', among them the 'drug' and 'natural' repertoires, described by Stephens and colleagues (2004) who contend that women may use these repertoires to describe their experience of HRT, but also to discursively position themselves as strong and capable, therefore not needing the 'prop' of medication. Looking at the words the women in our study used to describe their use of CAMs, they can similarly be read as women situating themselves within, or in opposition to, these discourses: The 'natural' repertoire is activated by women expressing the wish of using alternative treatments that are 'natural' or 'gentle' or 'less harmful'. Conversely, the 'drug' repertoire is activated with expressions like 'rattle', 'tablets' 'big bombs'

‘chemicals’ or ‘pills’. Physical contact CAMs offered the opportunity to be treated as a ‘whole person’ (Paterson & Britten, 2008); on the other hand, some women in our study saw the intense, close contact between practitioner and patient as problematic.

For those taking the ‘political-critical’ approach, prescription medicines and especially HRT were symptomatic of the toxic combination of commercial interest and alienation to the female body. This standpoint is expressed for example by Kelly (2008) who contrasts the ‘biomedical model’ driven by commercial interest and ageist assumptions to a ‘healthy approach’ to menopause as a universal natural phenomenon. The use of CAMs to regain control over health described by women in this study has been outlined in existing studies (Wathen, 2006; Will & Fowles, 2003). Women also linked the use of CAMs with overall understandings of midlife as a time for taking back one’s life, becoming a decision maker, more focus on self, and recognising the need to do more for one’s health. Similar responses were also described in Perz and Ussher’s (2008) study of the menopause, where participants resisted a medical discourse and described midlife as an age of confidence and wisdom from experience, and increased self-awareness and self-worth. This discourse of change is well represented in self-help literature around the menopause; however the female subject may be implicitly positioned as heterosexual with children leaving a family home (Lyons & Griffin, 2003). Some of the responses from the ‘wellbeing’ category saw this empowered change as unachievable for them; their wistful desire for ‘luxury’ physical touch treatments could be read as yearning for increased time and space for self. The ‘wellbeing’ category also showed the fluid boundaries between some CAMs and relaxing spa treatments.

In contrast to those for whom the use of CAMs was linked with political understanding of the female body and self or a more overarching project of self-empowerment at midlife, the largest group had a very pragmatic understanding of ‘what works’. Similar to participants in other research studies on CAMs, some found that conventional medicine could not help them, and/or they were looking for any kind of relief for their symptoms rather than a cure (Paterson & Britten, 1999). While research on CAMs has focused on those choosing CAMs, our study also includes the experiences of those who tried and rejected CAMs. The pragmatic approach could be related to a more general discourse that casts users of medicines as ‘smart consumers’, choosing, or rejecting, specific kinds of practitioners and treatments for particular problems (Kelner & Wellman, 1997).

While the perceived dichotomy between dangerous prescription drugs and safer CAMs has been well documented, participants in our study using the ‘careful’ approach could be positive towards CAMs or ambivalent, considering the possible danger arising from taking them, or combining them with conventional medications. This could be indicative of a more general mistrust of medicines (Pound, et al., 2005), where anything that could be construed as ‘pill’ was rejected. On the other hand, the careful approach could be due to a very specific health worry as with the two participants with diabetes who were unsure whether CAMs could affect their condition.

Conclusion

The analysis of women's perceptions and approaches related to CAMs revealed a set of complex experiences and choices. Women's health conditions and symptoms, perceived dichotomies between CAMs and conventional therapies, local accessibility of practitioners, money and time resources and enjoyment of physical touch therapies all played a role. CAMs were defined in contrast to conventional medications as safe, natural and ancient; on the other hand, most participants were happy to combine conventional and complementary medicines. For physical contact CAMs, direct touch by the practitioner was described as intuitive diagnostic, healing or luxurious; on the other hand, this closeness could be problematic or painful. We could also identify and categorise a 'overall approach' that dynamically interacted with these experiences. Those with a feminist, political-critical approach saw CAMs as 'alternative' more than 'complementary', although some women in this category used both. However, most women had a pragmatic approach to CAMs which could result in women embracing, accepting, or rejecting different forms of CAMs, or CAMs in general. Likewise, a careful approach could motivate women to use or reject CAMs. Those with a wellbeing-oriented perspective were often positive towards the idea of health-enhancing CAMs rather than the reality. The experience of midlife health, menopausal symptoms, other health conditions and medications and understandings of social and physical changes at midlife could all contribute to forming an overall approach to CAM and framing women's choice to use, consider, or reject CAMs.

References

- Astin, J. A. (1998). Why patients use alternative medicine: results of a national study. *JAMA*, 279(19), 1548-1553.
- Bair, Y. A., Gold, E. B., Azari, R. A., Greendale, G., Sternfeld, B., Harkey, M. R., et al. (2005). Use of conventional and complementary health care during the transition to menopause: longitudinal results from the Study of Women's Health Across the Nation (SWAN). *Menopause*, 12(1), 31-39.
- Banister, E. M. (1999). Women's midlife experience of their changing bodies. *Qualitative Health Research*, 9(4), 520-537.
- Borud, E. K., Alraek, T., White, A., Fonnebo, V., Eggen, A. E., Hammar, M., et al. (2009). The Acupuncture on Hot Flashes Among Menopausal Women (ACUFLASH) study, a randomized controlled trial. *Menopause*, 16(3), 484-493.
- Gingrich, P. M., & Fogel, C. I. (2003). Herbal therapy use by perimenopausal women. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 32(2), 181-189.
- Goldstein, M. (2000). The culture of fitness and the growth of CAM. In M. Kelner & B. Wellman (Eds.), *Complementary and alternative medicine: challenge and change*. Amsterdam: Harwood.
- Gollschewski, S., Anderson, D., Skerman, H., & Lyons-Wall, P. (2004). The use of complementary and alternative medications by menopausal women in South East Queensland. *Women's Health Issues*, 14(5), 165-171.
- Gollschewski, S., Kitto, S., Anderson, D., & Lyons-Wall, P. (2008). Women's perceptions and beliefs about the use of complementary and alternative medicines during menopause. *Complementary Therapies in Medicine*, 16(3), 163-168.
- Greer, G. (1991). *The change: women, ageing and the menopause*. London: Hamish Hamilton.
- Griffiths, F., Green, E., Backett-Milburn, K., Bendelow, G., Thompson, D., Tsouroufli, M. (2003). Innovative Health Technologies at Women's Midlife: Theory and Diversity among Women and 'Experts': End of Award Report (L218252038). The report can be accessed in full from the ESRC's website <http://www.esrcsocietytoday.ac.uk/ESRCInfoCentre>.
- Griffiths, F., Green, E., Bendelow, G. (2006). Health professionals, their medical interventions and uncertainty: a study focusing on women at midlife. *Social Science and Medicine*, 62(5), 1078-1090.
- Griffiths, F., Anto, N., Chow, E., Manazar, U., Van Royen, P., Bastiaens, H. (2007). Understanding the diversity and dynamics of living with diabetes: a feasibility study focusing on the case. *Chronic Illness*, 3(1), 29-45.
- Griffiths, F. (2009). *Research Methods for Health Care Practice*. London: Sage.
- Gullette, M. M. (2004). *Aged by Culture*. Chicago: University of Chicago Press.
- Hersh, A. L., Stefanick, M. L., & Stafford, R. S. (2004). National use of postmenopausal hormone therapy: annual trends and response to recent evidence. *JAMA*, 291(1), 47-53.
- Kelly, J. (2008). A lesbian feminist analysis of the demise of hormone replacement therapy. *Women's Studies International Forum*, 31, 300-307.
- Kelner, M., & Wellman, B. (1997). Health care and consumer choice: medical and alternative therapies. *Social Science and Medicine*, 45(2), 203-212.

- Leng, K.-W. (1996). On Menopause and Cyborgs: Or, Towards a Feminist Cyborg Politics of Menopause. *Body and Society*, 2(3), 33-52.
- Lyons, A. C., & Griffin, C. (2003). Managing menopause: a qualitative analysis of self-help literature for women at midlife. *Social Science and Medicine*, 56(8), 1629-1642.
- Manheimer, E., & Berman, B. (2008). Cochrane Complementary Medicine Field. *About The Cochrane Collaboration (Fields)*, 2008(Issue 2), Art. No.: CE000052.
- Miles, M., & Huberman, A. (1994). *Qualitative Data Analysis: An Expanded Sourcebook*. Thousand Oaks, CA.: Sage.
- Million Women Study Collaborators. (2003). Breast cancer and hormone replacement therapy in the Million Women Study. *Lancet*, 362, 419-427.
- Murtagh, M. J., & Hepworth, J. (2003). Menopause as a long-term risk to health: implications of general practitioner accounts of prevention for women's choice and decision-making. *Sociology of Health and Illness*, 25(2), 185-207.
- National Centre for Complementary and Alternative Medicine. (2007). *What is CAM?* Washington DC: National Institutes of Health: U.S. Department of Health and Human Services.
- Newton, K. M., Buist, D. S., Keenan, N. L., Anderson, L. A., & LaCroix, A. Z. (2002). Use of alternative therapies for menopause symptoms: results of a population-based survey. *Obstetrics and Gynecology*, 100(1), 18-25.
- Parkman, C. (2003). The furor over alternative therapy for menopause. *Case Manager*, 14(3), 32-34.
- Paterson, C., & Britten, N. (1999). 'Doctors can't help much': the search for an alternative. *British Journal of General Practice*, 49, 626-629.
- Paterson, C., & Britten, N. (2008). The patient's experience of holistic care: insights from acupuncture research. *Chronic Illness*, 4(4), 264-277.
- Perz, J., & Ussher, J. M. (2008). "The horror of this living decay": Women's negotiation and resistance of medical discourses around menopause and midlife. *Women's Studies International Forum*, 31, 293-299.
- Pound, P., Britten, N., Morgan, M., Yardley, L., Pope, C., Daker-White, G., et al. (2005). Resisting medicines: a synthesis of qualitative studies of medicine taking. *Social Science and Medicine*, 61(1), 133-155.
- Richter, D. L., Corwin, S. J., Rheaume, C. E., & McKeown, R. E. (2001). Perceptions of alternative therapies available for women facing hysterectomy or menopause. *Journal of Women and Aging*, 13(4), 21-37.
- Roberts, C. (2002). Successful aging with hormone replacement therapy: It may be sexist, but what if it works? *Science as Culture*, 11(1), 39-59.
- Seidl, M. M., & Stewart, D. E. (1998). Alternative treatments for menopausal symptoms: qualitative study of women's experiences. *Canadian Family Physician*, 44, 1271-1276.
- Stephens, C., Carryer, J., & Budge, C. (2004). To have or to take: discourse, positioning, and narrative identity in women's accounts of HRT. *Health*, 88(3), 329-350.
- Suter, E., Verhoef, M. J., Bockmuehl, C., Forest, N., Bobey, M., & Armitage, G. D. (2007). Inquiring minds: women's approaches to evaluating complementary and alternative therapies for menopausal symptoms. *Canadian Family Physician*, 53(1), 85-90, 84.

- Vashisht, A., Domoney, C. L., Cronje, W., & Studd, J. W. (2001). Prevalence of and satisfaction with complementary therapies and hormone replacement therapy in a specialist menopause clinic. *Climacteric*, 4(3), 250-256.
- Walker, G., de Valois, B., Davies, R., Young, T., & Maher, J. (2007). Ear acupuncture for hot flushes--the perceptions of women with breast cancer. *Complementary Therapies in Clinical Practice*, 13(4), 250-257.
- Wathen, C. N. (2006). Alternatives to hormone replacement therapy: a multi-method study of women's experiences. *Complementary Therapies in Medicine*, 14(3), 185-192.
- Will, C. I., & Fowles, W. (2003). Woman to woman: complementary therapy use in menopause. *Journal of Holistic Nursing*, 21(4), 368-382.